Jioint Review Committee on Education in Radiologic Technology
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www.jrcert.org

APPLICATION FOR RECOGNITION OF A CLINICAL EDUCATION SETTING IN RADIATION THERAPY FORM 104T

Sponsoring Institution: _____ **Program #** _____

I. CLINICAL EDUCATION SETTING FOR WHICH JRCERT RECOGNITION IS SOUGHT:

_____
Name

_____
Address

_____ _____ _____
City State Zip Code

CES # _____ **(To be assigned by JRCERT)**

This application must be completed for each clinical education setting.

- Consistent with **JRCERT Policy 11.400, Procedure 11.404D**, the JRCERT considers a clinical education setting as all radiologic facilities under a single radiologic administration within the campus. A campus is defined as the buildings and grounds of a school, college, university, or hospital that are geographically contiguous and does NOT include any geographically dispersed campus of a sponsor. Separate recognition is required for each facility not meeting this definition.

- **Enclose:**
  a. An affiliation agreement with Affiliation Agreement Criteria sheet attached (see page 8).
  b. **Form 102T** for each designated clinical supervisor and all required attachments identified on the form.
  c. Documentation of **current** The Joint Commission (TJC) accreditation or equivalent for the clinical education setting for which recognition is sought. For non-hospital clinical education settings that are not accredited, documentation of compliance with state and/or federal radiation safety regulations may be used as equivalent

  NOTE: Clinical Capacity Calculation Guidelines, page 5, is used by the JRCERT to identify the student capacity of the clinical education setting. DO NOT complete this page

- An application for recognition is not guaranteed. Recognition may be denied, or the capacity authorized may be less than that requested by the program.

- **Fee** - please see the current Fee Schedule at www.jrcert.org.

II. INSTITUTIONAL/PROGRAM OFFICIALS:

The signatures of clinical education setting and program director constitute a request for JRCERT recognition of the facility as a clinical education setting for the requesting program.

A. Chief Executive Officer of Clinical Education Setting:

Name (Print)	Degree /Credentials	Title

Signature

B. Clinical Supervisor(s):

Complete JRCERT **Form 102T**, and provide a **current** curriculum vitae, and documentation of **current ARRT** registration or unrestricted state license **for each individual listed**. **Duplicate and add additional Form(s) and/or page(s) as necessary.)**

- **A minimum of one clinical supervisor must be identified for each clinical education setting.**
- One full-time equivalent clinical supervisor must be identified for every ten (10) students involved in the competency achievement process.

Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials
Name	Degree/Credentials

Provide documentation of baccalaureate or higher degrees. (*Although not required for clinical supervisors, the JRCERT database will eflect degrees only upon submission of appropriate documentation. If degree documentation is not received for a clinical instructor, it will be assumed that the program does not wish to have the degree noted.)* Documentation of the appropriate degree attainment from an academic institution accredited by an agency recognized by the United States Departemt of Eduction (USDE) or the Council for Higher Education Accreditaition (CHEA)

III. CLINICAL CAPACITY - the JRCERT will determine the clinical capacity for this facility based on documented availability of appropriate therapy equipment and qualified practitioners to assure student attainment of program learning outcomes.

A. Physical Resources - List each of the treatment and simulation units at the facility and indicate the type. Please **check the ONE description** that best identifies the equipment. **[Duplicate and add additional page(s) as necessary]**

Room Identification (#, name, or other identifier)	Treatment	Simulation
______________________	☐	☐
______________________	☐	☐
______________________	☐	☐
______________________	☐	☐
______________________	☐	☐
______________________	☐	☐
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______________________	☐	☐
______________________	☐	☐

B. **List the qualified practitioners** (ARRT or equivalent) that are assigned to ***a typical weekday*** (Monday-Friday) who perform therapy procedures. Indicate the primary area of daily practice and include shift hours. **The ratio of students to staff shall not exceed 1:1** [Duplicate and add additional page(s) as necessary.] **.**

Name of Therapist	Treatment	Simulation	Other *(specify)*	Shift Hours Begin	end
	☐	☐		:	
	☐	☐		:	
	☐	☐		:	
	☐	☐		:	
	☐	☐		:	
	☐	☐		:	
	☐	☐		:	
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	☐	☐		:	
	☐	☐		:	

IV. CLINICAL TOTAL CAPACITY CALCULATION GUIDELINES

THIS PAGE WILL BE COMPLETED BY THE JRCERT.

The following serve as guidelines for determining the total clinical capacity for the clinical education setting.

Type of Equipment	Number of Units	Multiplier		Subtotal
Treatment		1		
Simulation		1		
Other _____				
	Total Physical Resources **Based on information from Section III,A**			
	Total Personnel Resources **Based on information from Section III,B**			
	Total Clinical Capacity (TCC) **Based on lower of two above numbers**			

Recognized Program # _____ CC _____

Recognized Program # _____ CC _____

Recognized Program # _____ CC _____

CC Available for Applicant Program _____

V. SITE UTILIZATION

A. **Program seeking recognition for use of this facility**. In the chart below, beginning with "Shift A", indicate the requested number of 1st year students to be assigned and the beginning and ending time of each day's rotation. If students are assigned to a second start/end time, please indicate in the "Shift B" section. If all students are assigned to the same start and end times, skip the "Shift B" section. Repeat these steps for the 2nd year students.

	Monday	Tuesday	Wednesday	Thursday	Friday
1st Year - "Shift A" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*
1st Year - "Shift B" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*
2nd Year - "Shift A" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*
2nd Year - "Shift B" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*

Please indicate the terms in which the students are assigned to this clinical education setting.

1st Year - ☐ Fall ☐ Spring ☐ Summer ☐ Other _____ *Please indicate*

2nd Year - ☐ Fall ☐ Spring ☐ Summer ☐ Other _____ *Please indicate*

Based on the recognition of this facility, the program's total capacity will:

☐ remain the same OR ☐ increase by _____ students

SHARED SITE INFORMATION - if not a shared site move to page 7.

This section is to be completed by the program director of the currently recognized JRCERT accredited program. **(If the site is currently used by more than one other program, information must be provided on separate sheets for each.)**

NOTE: If the total number of students identified in the sections below is less than the number currently on the JRCERT database for the program at this facility, the clinical capacity will be decreased to the number indicated.

B. **Name** of program **currently recognized** for use of this facility - _____ *Name of Program*

Recognized programs's JRCERT#: _____

For directions to complete, see Section "A" above.

	Monday	Tuesday	Wednesday	Thursday	Friday
1st Year - "Shift A" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*
1st Year - "Shift B" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*
2nd Year - "Shift A" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*
2nd Year - "Shift B" _____ *# of Students*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*	___:___ - ___:___ *begin end*

Please indicate the terms in which the students are assigned to this clinical education setting.

1st Year - ☐ Fall ☐ Spring ☐ Summer ☐ Other _____ *Please indicate*

2nd Year - ☐ Fall ☐ Spring ☐ Summer ☐ Other _____ *Please indicate*

Programs should use this section to document comments.

RADIATION ONCOLOGY DEPARTMENTAL ADMINISTRATOR

I agree that the information provided on this form is correct.

Name (Print) Title

Signature

PROGRAM DIRECTOR - PROGRAM SEEKING SITE RECOGNITION

I agree that the information provided on this form is correct and that if recognition of this site is granted, the program will abide by the usage of the site as proposed.

Name (Print)

Signature

PROGRAM DIRECTOR - PROGRAM HOLDING CURRENT SITE RECOGNITION.
To be completed ONLY if site is to be shared.
Pages 6 & 7 must be completed by ALL programs with current site recognition (including those sites identified as inactive).

I agree that the information provided on this form is correct and that the program will abide by the usage of the site described on page 6.

Program #:

Name (Print)

Signature

VI. AFFILIATION AGREEMENT CRITERIA:

Attach a copy of this page to the front of the signed affiliation agreement submitted.

Sponsoring Institution: _____ **Program #** _____

Clinical Education Setting Name: _____

The affiliation agreement must identify the following three (3) criteria as outlined below. Please identify where they are located by highlighting, circling, or otherwise indicating the verbiage in the body of the agreement and identifying the page and paragraph number in the space provided below.

☐ RESPONSIBILITY FOR STUDENT SUPERVISION:

Page and Paragraph Number _____

☐ ADEQUATE NOTICE OF TERMINATION OF THE AGREEMENT:

Page and Paragraph Number _____

The JRCERT considers three (3) months notice of termination or assurance that students currently enrolled and assigned to the facility will be able to complete their clinical assignment at the facility.

☐ RESPONSIBILITY FOR LIABILITY:

Page and Paragraph Number _____

NOTE: An affiliation agreement is not required for clinical education settings owned by the sponsoring institution. In these instances; however, a memorandum of understanding is encouraged.